Halving Maternal Deaths: A Strategy for the 1990s

Address by
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to the
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Speaking at the Meeting of Partners for Safe Motherhood, at World Bank headquarters in Washington, D.C., on 9 March 1992, UNICEF Executive Director James P. Grant outlined the "three pillars" of a strategy that can cut in half — by the year 2000 — the 500,000 maternal deaths taking place each year throughout the developing world. In summary, they are:

1) pregnancy only for those who want a baby;

2) do no harm to yourself or your baby — have a clean, safe delivery with trained help;

3) know when to seek help, have pre-arranged transport and know where to go for emergency obstetric care — a simple, adequately supplied and staffed, accessible facility.

Together with public education, social mobilization, female equality and the general strengthening of grassroots participation and democracy, these are "important factors that will help assure that the generation of women growing up in this decade will be the healthy mothers of the first generation born in the next millennium." Mr. Grant urged the partners in the Safe Motherhood Initiative — the World Bank, United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), the World Health Organization (WHO), International Planned Parenthood Federation, the Population Council and UNICEF — to intensify their programmatic, funding and advocacy efforts to ensure that women and couples are empowered to make pregnancy and childbirth the welcome, healthy and safe milestone events they should be.

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There is something very wrong, something obscene and hypocritical, about a world that universally exalts motherhood and yet permits hundreds of thousands of maternal deaths year in and year out from causes that are now largely preventable. There is something very wrong about a world that tells women that motherhood is their route to realization and status and yet denies so many of them the means to prevent or remedy the dangerous complications that can be associated with pregnancy and childbirth. There is something very wrong about a world on the threshold of the 21st century that allows so many women to approach childbirth so weakened from preventable malnourishment and disease that they risk their very lives. There is something very wrong about a world that does not effectively empower women and couples with the basic knowledge and low-cost, culturally acceptable means to prevent unwanted pregnancies or pregnancies among high-risk categories of mothers.

Last year, as we are now aware, at least half a million women died from causes related to pregnancy and childbirth. The maternal death toll is expected to be similar this year and throughout the decade, totalling 5 million by the year 2000. For each one of the 500,000 maternal deaths each year, it is estimated that 15–20 women suffer some form of lifelong disability as a result of complications associated with pregnancy and childbirth. *Fully 90 per cent of these deaths and disabilities can be prevented.* The knowledge and tools for preventing them exist, but they have not been made available to those who need them most. The fact that 98 per cent of all maternal deaths occur in the developing countries is one of the most shocking indictments of the gap between North and South which threatens to become unbridgeable as we approach the third millennium. An equally shocking indictment of the development policies of most countries is that we now know how to prevent a majority of maternal deaths in low-income countries. For example, if all of South Asia had the maternal mortality rates of Sri Lanka, maternal deaths

would be reduced from the present 200,000 annually to some 25,000 annually! After all, what does it say about the state of human civilization that the average African woman faces a 1 in 20 risk of dying from causes related to maternity, while in Sri Lanka, the lifetime risk is 1 in 500 and in Europe it is 1 in several thousand? Such a state of affairs should be unacceptable, I am sure we all agree, in any meaningful new world order to be shaped out of the post–Cold War world. Morality must march with changing capacity.

This is what triggered the Safe Motherhood meeting in Nairobi five years ago. Today, the issue is much more widely known. But, the death toll has changed very little. This meeting of Partners for Safe Motherhood is, therefore, most timely, and I would like to thank our friends at the World Bank for organizing and hosting it. The fact that we have World Bank President Lewis Preston here with us today demonstrates that we have "heavy fire-power" behind our collective safe motherhood efforts. As several have already said, it is in our power — here this week — to give new impetus to our Safe Motherhood Initiative, taking advantage of the extraordinary changes that have taken place in the world in recent years and the renewed interest in human development we have seen among the international community.

One important change, as you know, was the World Summit for Children. Held at UN Headquarters in September 1990, it was the first summit gathering of this new era, the first global expression of top-level political will to invest in human development in a major way. Seventy-one heads of State and Government and senior representatives from another 88 countries — from East and West, North and South — agreed, for the first time, to give children a "first call" on society's resources. And they committed themselves to a Plan of Action to make this happen in every country by the year 2000.

In taking a hard look at the tragedy of 14 million largely preventable child deaths each year, the world's leaders adopted a holistic approach. They examined the complex issues of child survival, protection and development in the context of overall human development, the strategic struggle against poverty, the urgent effort to save the environment and the pressing need for gender equity.

They stressed in their Declaration that "strengthening the role of women in general and ensuring their equal rights will be to the advantage of the world's children. Girls must be given equal treatment and opportunities from the very beginning."

Taking note of the half million deaths each year from causes related to childbirth, the leaders stated: "Safe motherhood must be promoted in all possible ways. Emphasis must be placed on responsible planning of family size and on child spacing."

They committed themselves to a 10-point programme, point 4 of which reads: "We will work to strengthen the role and status of women. We will promote responsible planning of family size, child spacing, breast-feeding and safe motherhood."

And in the World Summit for Children Plan of Action, they committed themselves, as articulated earlier at the Nairobi Safe Motherhood Conference, to *reduce maternal mortality rates to half* of 1990 levels, through giving

- special attention to the health and nutrition of the female child and to pregnant and lactating women;
- access by all couples to information and services to prevent pregnancies that are too early, too closely spaced, too late or too many;
- access by all pregnant women to prenatal care, trained attendants during childbirth and referral facilities for high-risk pregnancies and obstetric emergencies;
- universal access to primary education with special emphasis on girls and accelerated literacy programmes for women.

They agreed, also, to the goal of reducing iron deficiency anaemia in women by one third of 1990 levels; to immunize virtually all women of child-bearing age against tetanus; to empower all women to breastfeed their children exclusively for four to six months; and to promote increased food production and household food security.

The endorsement of these principles and goals of particular relevance to women and the girl child by a majority of the world's most powerful leaders should give the Safe Motherhood Initiative a vital boost. In accordance with the Summit Plan of Action, countries around the world are now drafting, finalizing or issuing National Programmes of Action to implement the year 2000 goals — including those relating to women, which I have just

mentioned. Donor countries are not only drafting plans to improve the lot of their own children, but are re-examining their official development assistance budgets to make them more supportive of these goals. International agencies such as our own — as well as non-governmental organizations — are responding to the call of the World Summit for Children in diverse ways, and re-launching the Safe Motherhood Initiative is one of the most important things we can do.

A second major change is the additional leverage for advocacy and programmatic action provided by the Convention on the Rights of the Child, which entered into force on the eve of the World Summit and is now the law of the land in 110 countries. This extraordinarily comprehensive "Bill of Rights", this "Magna Carta" for children, also obligates States Parties — in Article 24 — "to ensure appropriate prenatal and post-natal health care for mothers". In other words, what we Partners for Safe Motherhood have been focusing on as *needs* have now been elevated to the level of *rights* by the international community and formally recognized as *priorities* by the leaders of the world. We have yet to take full advantage of this critical conceptual shift, this ethical breakthrough, in our cooperation with governments, in our advocacy with donors and in our development programmes with grass-roots communities.

How can we meet the goal of halving the number of maternal deaths by the year 2000 in the context of the major push for overall human development that is required? It seems to me that we must work at two levels simultaneously if we are to succeed. We must take a long-term, preventive approach that addresses many of the underlying causes and contributors to maternal mortality, while promoting short- and medium-term solutions that significantly reduce the death and disability toll in the here and now. Over the long haul, we must do everything that can be done to ensure that, by the time they contemplate motherhood, women are healthy, well nourished and well informed; that couples bring only *wanted* children into the world, preferrably when the mother is between the ages of 18 and 35, with adequate spacing between each birth; and that families and communities provide pregnant women and mothers the support and services they need, including adequate prenatal care and childbirth attended by trained health personnel. Strengthening

the primary health care system is key. Educating the girl child is clearly another effective long-term solution.

In the long run, then, prevention is the way to go. It is unlikely, however, that preventive efforts will ever completely solve the problem. Even under optimum conditions, it seems, complications can and will arise during a certain number of pregnancies, births and their aftermaths. As we work to help create those "optimum conditions", we must strengthen the developing world's capacity to handle the complications and emergencies that account for the unnecessarily high maternal death toll we have today.

What can we do to accelerate progress towards our goal? When I was an infantry soldier and we'd come to a bridge that was down, we didn't wait six months for a new one to be built to cross the river; we put up, in 24 to 78 hours, a temporary "Bailey Bridge", as it was called, strong and wide enough to drive heavy equipment across. Well, I would describe the constellation of necessary safe motherhood interventions as a "Bailey Bridge" approach, one that does not solve the entire problem on a long-term basis but is readily "doable" in this decade and brings us a large part of the way.

1) *Maternal deaths could be reduced by one fourth to one third of present levels, i.e., about 125,000–175,000 lives of mothers, if couples that did not want to have a baby were able to safely and effectively avoid pregnancy and thereby avoid dangerous abortions.* Women too young and too old contribute up to 20 per cent of births (even more in some countries) — many of these births are unwanted. World fertility and other surveys have shown as many as one third of pregnant women stating they would have preferred *not* to have another baby. The means to avoid pregnancy will vary by culture and country, but all women (and their spouses) should have the right and means to choose and plan when or when not to get pregnant.

2) *If a woman — a couple — decides to have a baby, there are simple things that must be done to keep the mother and baby healthy. Here the watchword is: DO NO HARM.* If no harm is done, this would save another 10–15 per cent, i.e., 50,000–75,000 lives. Antenatal care will help protect mother and child from tetanus (through TT injection), from anaemia (by giving iron folate

tablets), and will identify early problems (high blood pressure) and arrange for those clearly at risk to deliver their babies in appropriate institutions. For most women, delivery in or near their own home, assisted by a person trained in basic cleanliness and normal, safe delivery procedure, will assure that no harmful practices place the mother or baby at undue risk. These measures can be expected to reduce maternal death by a further 10–15 per cent.

All mothers, their families and especially those assisting in the delivery must know the simple signs that indicate a problem: haemorrhage, prolonged labour, the baby coming out the wrong way, etc. Timely decision to transport the mother to a facility that can provide the needed obstetric care, and the means to get there as quickly as possible, are life saving. Delay in this decision, or in reaching care, can be fatal. Here the health system can reach out towards the community, assuring proper training of birth attendants, allowing paramedic workers to give drugs to slow bleeding and permitting them to facilitate transport services. By "meeting the community half way", every woman will have access to help when needed, even if obstetric services are far away in urban centres.

3) *For those few who develop a life-threatening condition during pregnancy, and especially during delivery, reliable essential obstetric emergency care is needed.* No doubt, in the long run hospitals with a full array of obstetric services, equipment and support are desirable. But even today, many health systems are unable to provide emergency obstetric care for lack of modest equipment or facilities costing relatively little. Even where medical personnel exist who have been trained to perform Caesarean section or otherwise manage obstetric obstruction, and to provide life-saving transfusion to a mother or to treat serious infections or convulsions, lack of the most rudimentary equipment and supplies may lead to unnecessary maternal death.

There are, essentially, five components to a minimally acceptable, low-cost obstetric emergency package:

- a basic surgical kit for Caesarean section in a clean, simple operating room;
- simple anaesthesia;
- safe blood and transfusion supplies;
- essential antibiotics and intravenous fluids;
- anti-convulsants and anti-hypertension agents.

These five constitute the bare essentials that should be present in each and every facility where emergencies can be referred to save lives. Providing these essentials does not require the elaborate infrastructure of industrialized societies. This type of simple obstetric service was extended throughout Sri Lanka in the two decades following World War II, bringing maternal mortality ratios from 560 in 1950 to the present level of 60.

Recently — as a result of Matlab in Bangladesh — maternal mortality levels were reduced from 400 per 100,000 births to under 200, through the rising use of contraceptives (now 60 per cent); conventional antenatal care (over 80 per cent); training of traditional birth attendants in the village with backup from midwives (1 per 20,000 population); a nearby cottage hospital handling the simpler obstetric complications, with a district hospital (no more than 40 minutes away by car) capable of Caesarean section and transfusion, and a reliable, though simple system of boats, pedicabs and locally available vehicles to link people to their facilities.

The whole system, not just one part of it, seems essential to bringing maternal mortality down sharply: fertility control, antenatal care, clean home delivery, midwife assistance for problems, nearby referral for less demanding obstetric emergencies and an accessible hospital to handle the most demanding and likely fatal complications. This, plus improved systems for collecting accurate data concerning maternal deaths, is what is needed. All together are essential.

This simple, bare-bones, transitional approach is clearly not the final answer — surely, more developed structures and services are needed to enable maternal mortality rates to drop everywhere below 100 and further. But it is adequate now to reduce the current average for the developing world — 450 — to half that level or less, say, to 200 or 225. But, like immunization, it must be available everywhere. Access to this essential obstetric backup is needed within the existing system of health care now. This meeting should resolve to help make this happen over the current decade, even as we lay plans for better, more comprehensive facilities with full surgical capacities, blood banks, X-rays, ultra sound, foetal monitors and the like.

In summary, the following three pillars, provided people demand and use them, will enable us to achieve

our goal of a reduction by one half in maternal mortality by the year 2000:

1) pregnancy only for those who want a baby;

2) do no harm to yourself or your baby — have a clean, safe delivery with trained help;

3) know when to seek help, have pre-arranged transport and know where to go for emergency obstetric care — a simple, adequately supplied and staffed, accessible facility.

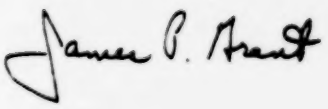
Thus, public education, social mobilization, female equality and the general strengthening of grass-roots participation and democracy are important factors that will help assure that the generation of women growing up in this decade will be the healthy mothers of the first generation born in the next millennium.

UNICEF has been involved in activities related to safe motherhood for over four decades, mainly in the area of antenatal care. We have stressed training of traditional birth attendants and have supported training of midwives and community health volunteers. We have provided iron and folic acid to pregnant women to overcome anaemia. Since 1987, with the launching of the Safe Motherhood Initiative, we have actively participated in the Inter-Agency Group on Safe Motherhood. In our country programmes, we have stressed the girl child, female literacy, family planning, and empowerment of women to overcome disadvantage and discrimination. We have developed a field staff training package on safe motherhood that will be implemented this year.

Work in education, nutrition and antenatal care is essential, but it is clearly not enough. We will not appreciably advance towards our year 2000 goal without the upgrading of accessible first referral facilities to handle obstetric emergencies. Only a greatly strengthened international partnership of governments, international agencies such as our own and NGOs can bring this about. In particular, I would urge that all the international agencies get their people on the ground, in countries around the world, to help see to it that the safe motherhood promises of the World Summit for Children are kept, and that the National Programmes of Action translate these promises into realistic and "doable" programmes. In our meetings with world leaders, the heads of the World Bank, UNDP, UNFPA, WHO, UNICEF and other agencies should raise

the issue of safe motherhood, emphasizing that we can halve maternal mortality even before the year 2000, in only five years, even where it is currently very high — if we really give ourselves over to the task. We must also see to it that the November 1992 International Conference on Assistance to African Children takes up safe motherhood issues as a principal topic of discussion.

The "Bailey Bridge" approach I have outlined here today will rapidly carry us forward, as we work on longer-term improvement in the status and education of women, and as we strengthen health systems in all countries. The measures I have suggested carry a not-insubstantial price tag, but one that is certainly affordable now that the end of the Cold War has made it possible to redirect vast resources from military to peaceful uses. Beating swords into the ploughshares of better lives for women, for children, for people everywhere is the central challenge of our times.



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